Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Clydell Adams, Jr., DC

Respondent Name
Texas Mutual Insurance Carrier

MFDR Tracking Number
M4-15-0607-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
October 14, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I would like to request assistance in obtaining the balance for the service provided on 01/24/2014. An attempt was made to the carrier in a request for reconsideration with a copy of our fax confirmation showing that the claim was submitted to the carrier 7 days after date of service and the response was an EOB stating that the time limit for filing has expired."

Amount in Dispute: $1000.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "1. CLYDELL ADAMS JR DC provided services to the claimant on 1/24/2014.

2. Rule 133.250(a) states, 'If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill, the health care provider may request that the insurance carrier reconsider its action.' And at (i) 'if the health care provider is dissatisfied with the insurance carrier's final action on a medical bill after reconsideration, the health care provider may request medical dispute resolution in accordance with the provisions of Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills).'

   133.307(c)(2)(J) states, 'Health Care Provider or Pharmacy Processing Agent Request. The requestor shall provide the following information and records with the request for MFDR in the form and manner prescribed by the division. The provider shall file the request with the MFDR Section by any mail service or personal delivery. The request shall include…a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier in accordance with this chapter and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter (relating to General Medical Provisions)…';

3. CLYDELL ADAMS JR DC's DWC60 packet contains evidence of only one bill submission and no evidence a request for reconsideration was submitted to Texas Mutual. For its part Texas Mutual only has the on bill in its claims processing system and no record of receiving an appeal.

4. Rule 133.307(f)(3)A) says 'The division will review the completed request and response to determine appropriate MFDR action… The division may dismiss a request for MFDR if…the division determines that the medical bills in the dispute have not been submitted to the insurance carrier for an appeal, when required.'

Texas Mutual urges DWC MDR to dismiss CLYDELL ADAMS JR DC's request as it is incomplete.

No payment is due."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 24, 2014	Designated Doctor Examination	$1000.00	$750.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 (b) affirms the filing deadline for medical bills.
3. Texas Labor Code §408.027 defines the requirements for payment of a health care provider.
4. 28 Texas Administrative Code §134.204 sets out the procedures for billing and reimbursing Designated Doctor Examinations.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-29 – The time limit for filing has expired.
   - 731 – Per 133.20 Provider shall not submit a medical bill later than the 95th day after the date the service, for services on or after 9/1/05

Issues

1. What is the correct MAR for the services in dispute?
2. Did the requestor forfeit the right to reimbursement for the services in dispute?

Findings

1. Per 28 Texas Administrative Code §134.204 (i)(1), "(C) Extent of the employee's compensable injury shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier 'W6;' (F) Issues similar to those described in subparagraphs (A) - (E) of this paragraph shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier 'W9.'"

   Additionally, per 28 Texas Administrative Code §134.204 (i)(2), "When multiple examinations under the same specific Division order are performed concurrently under paragraph (1)(C) - (F) of this subsection: (A) the first examination shall be reimbursed at 100 percent of the set fee outlined in subsection (k) of this section; (B) the second examination shall be reimbursed at 50 percent of the set fee outlined in subsection (k) of this section."

   Further, 28 Texas Administrative Code §134.204 (k) states, "The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier 'RE.' In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports."

   Review of the submitted documentation finds that per the order from the Division, the requestor performed an examination to determine the extent of injury. **Therefore the correct MAR for the examination to determine extent of injury is $500.00.** The requestor also performed an examination to answer similar questions. **Therefore the correct MAR for the examination for similar questions is $250.00.**
2. 28 Texas Administrative Code §133.20(b) requires that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided."

   Texas Labor Code §408.027(a) states, in pertinent part, that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." 28 Texas Administrative Code §102.4(h) states that "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission."

   A review of the submitted documentation finds that the great weight of evidence indicates that the requestor successfully submitted a complete medical bill by fax to the insurance carrier on February 5, 2014 at 10:19 AM. For this reason, the Division finds that the insurance carrier received the bill within the required 95 days after the date of service. **Therefore, the requestor does not forfeit the right to reimbursement for the services in dispute.**

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $750.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $750.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	January 15, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.